MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11924

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Springfield State Hospital
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 years, 6 months, 9 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 36 years, 6 months, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2. (a) If veteran, name war:

3. (a) FULL NAME: Susanna Ashton

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	single

6. (b) Name of husband or wife:
6. (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1868

8. AGE: Years	Months	Days	If less than one day
78	unknown		hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: milliner
11. Industry or business

FATHER
12. Name: John M. Ashton
13. Birthplace: Maryland

MOTHER
14. Maiden name: Susanna Ashton
15. Birthplace: England

16. Informant: Hospital record
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-28-46 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Balto. Md.
18. Funeral director: George Weber
Address: 2503 Elmandson ave.

19. Dec. 26 1946 (Date rec'd by registrar) C. Harry Weber Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25, 1946 at 10.25p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 1942 to December 25 1946 and that I last saw her alive on December 25 1946

Immediate cause of death	DURATION
chronic myocarditis	10 years
Due to: arteriosclerosis	10 years
Due to:	
Other conditions: schizophrenia, paranoid type	37 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irene H. Hekman, M. D.
M. D. or other
Address: Springfield State Hospital Date signed: 12-25-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11925

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 17 days
Hospital, Institution, or street address where [illegible]
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Towson, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 125 E. Chesapeake Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Willie Mae Banks

3.(b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1922

8. AGE: Years	Months	Days	If less than one day
24	9	27	hrs. min.

9. Birthplace Coconut Grove, Fla.
(Town, county, and state)
10. Usual occupation none
11. Industry or business
FATHER 12. Name Elliott Banks
13. Birthplace Georgia
MOTHER 14. Maiden name Jane Edwards
15. Birthplace Atlanta, Ga.
16. Informant Deceased
Address
17. Burial Date thereof 12-11-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Pleasant Rest
Location Towson, Md.
18. Funeral director Mrs. Byron Wright
Address 722 Augusta St., Balto.
19. 12-10-46 19 Albert R. Swarbham deputy local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9, 1946 at 10.55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22, 1946 to Dec., 9, 1946 and that I last saw her alive on Dec., 9, 1946

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Sept. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben D. Bowman M.D.
M. D. or other
Address Henryton, Md. Date signed 12/10/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25

2-740-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11926

CERTIFICATE OF DEATH

(13-P) BC ★ Reg. Dist. No. 74 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 26 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 521 N. Bethel Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: CHARLES BANTUM

3.(b) Social Security Number: 218-07-6869

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept., 5, 1905

8. AGE: Years	Months	Days	If less than one day
41	3	4	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Stock Clerk
11. Industry or business

FATHER
12. Name: Eugene Bantum
13. Birthplace: Maryland

MOTHER
14. Maiden name: Alice Giles
15. Birthplace: Maryland

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 13/1946 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cemetery
Location: A A Co Md
18. Funeral director: Robert E. Williams
Address: 515 McElderry St

19. 12/9 (Date rec'd by registrar) 19 46 Albert L. Swarthem Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 9, 19 46 at 12.45 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 13, 19 46 to Dec., 9, 19 46 and that I last saw h im alive on December 9, 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1945
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Braun, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 12/9/46

1-25

2-740- 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

11927

Reg. Dist. No. 761

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred: Carroll Co Helms House

How long in hospital or institution? 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Carroll Co Alms House

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Lewis Guy Barnhart

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary Wall Barnhart Deceased

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1880

8. AGE:

Years	Months	Days	If less than one day
66			..... hrs. ..... min.

9. Birthplace: Carroll Co Md (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business:

FATHER

12. Name: Geo. Barnhart

13. Birthplace:

MOTHER

14. Maiden name: Catherine Bowers

15. Birthplace: Maryland

16. Informant: Mr. Geo. W. Barnhart

Address: Westminster, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-26-46 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Snydersburg Md

18. Funeral director: Ward & Myers Sons

Address: Manchester Md

19. 12/26 (Date rec'd by registrar) 19 46 Ray Fuhr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-23 1946 at 7.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 9 1944, to 12-23 1946

and that I last saw him alive on 12-22- 1946

Immediate cause of death: Cardiac decompensation 10 dys

Due to: Interstitial nephritis

Due to: Fibrous Cirrhosis of the Liver 9 years

Due to:

Other conditions:

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations: No

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. A. Hope M. D. or other

Address: Westminster Date signed 12-28-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-25

2-760 ——— 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P 11928 Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr 1 mo 9 da

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 1 yr 1 mo 9 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1411 LINDEN AVE (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Jean Mary Barrett.

3. (b) Social Security Number: 215-01-4991

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife: * *

6.(c) If alive, give age: * years

7. Birth date of deceased (mo., day, yr.): Dec 1st - 1880

8. AGE: Years: 66 Months: 0 Days: 7 If less than one day: hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Waitress

11. Industry or business:

FATHER 12. Name: William Barrett

13. Birthplace: Baltimore

MOTHER 14. Maiden name: Mary Fitzpatrick

15. Birthplace: Ireland

16. Informant: Father Buckley Priest

Address: Royal & Lafayette Sts. Balto.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: DEC. 11-46 (month) (day) (year)

Cemetery or crematory: CATHEDRAL

Location: OLD FREDERICK

18. Funeral director: CHAS. F. EVANS & SON

Address: 118 W. Mt. Royal Ave.

19. 12-9 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 8th 1946, at 8-15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 29th 1945 to Dec 8th 1946 and that I last saw h alive on Dec 8th 1946

Immediate cause of death: Carcinoma of Uterine Cervix — DURATION: 2 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. J. Austin M. D. or other

Address: Sykesville Md. Date signed: 12-9-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

11929

Reg. Dist. No. 240

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 27 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 2 months, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D. #5
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Francis Ignatius Albert Beaver

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

6.(b) Name of husband or wife: Grace Florida Hook

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): January , 1878

8. AGE: Years	Months	Days	If less than one day
68	11		____ hrs. ____ min.

9. Birthplace: Carroll County, Maryland
(Town, county, and state)

10. Usual occupation: farmer

11. Industry or business: agriculture

FATHER
12. Name: Nelson Beaver
13. Birthplace: Carroll County, Maryland

MOTHER
14. Maiden name: Mary ~~~~ ?
15. Birthplace: Carroll County, Maryland

16. Informant: Springfield State Hospital Records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 2. 1947 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster, Md.

18. Funeral director: H Bankard & Son

Address: Westminster, Md.

19. Jan. 1 1947 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 31 1946 at 5:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 21 1946 to Dec. 31 1946 and that I last saw him alive on December 31 1946

Immediate cause of death	DURATION
Cerebral thrombosis	12 hrs.
Due to: Arteriosclerosis, prior to	1943
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	4 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
M. D., or other

Springfield State Hospital
Address: Sykesville, Maryland Date signed: 12-31-46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

11930

CERTIFICATE OF DEATH

Reg. Dist. No. 720

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster, R.D.I (Myers District)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster, R. D. I
(If outside city or town limits, write RURAL and give nearest town)
Street No. Myeras District
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lillie May Bechtel

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Howard L. Bechtel
6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): December 10 1879

8. AGE: Years	Months	Days	If less than one day
67	0	6	...hrs. ...min.

9. Birthplace: Adams County Pa.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Housewife
FATHER 12. Name: Aaron Null
13. Birthplace: Adams County, Pa.
MOTHER 14. Maiden name: Alice Leese
15. Birthplace: Adams County, Pa.
16. Informant: Howard L. Bechtel
Address: Westminster, Md. R. D. I
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 18 1946 (month) (day) (year)
Cemetery or crematory: St. Bartholomew Cemetery
Location: York County, Penna.
18. Funeral director: F. W. Little & Son
Address: Littlestown, Pa. Per B. A. L.
19. Dec. 16 - 1946 (Date rec'd by registrar) Calvin Bankert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 1946 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1946 to Dec 16 1946 and that I last saw her alive on December 16 1946 and that death occurred on the date above stated.

	DURATION
Immediate cause of death: Coronary occlusion	several hrs.
Due to: Arteriosclerosis (General) Diabetes mellitus	several yrs.
Due to:	
Other conditions: Chronic Cholecystitis (Include pregnancy within 3 months of death)	several yrs

Major findings of operations: ...Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. Glenn Speicher M. D. or other
Address: Westminster Md Date signed 12/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11931

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months, 1 day
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Benning, Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6025 Sheriff Rd., Fairmount Heights
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SAMUEL JUNIOR BOBO

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 14, 1927

8. AGE: Years	Months	Days	If less than one day
19	5	9	hrs. min.

9. Birthplace: Leesville, S.C. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
12. FATHER — Name: Yancey Bobo
13. FATHER — Birthplace: South Carolina
14. MOTHER — Maiden name: Sally Jones
15. MOTHER — Birthplace: South Carolina
16. Informant: Deceased
Address
17. Buried (Burial, cremation, or removal. Which?) Date thereof 12/29/46 (month) (day) (year)
Cemetery or crematory
Location: Leesville, S.C.
18. Funeral director: Arthur L. Rollins
Address 4339 Hunt Pl. N.E.
19. Dec. 23, 19 46 (Date rec'd by registrar) Albert C. Grandhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 23, 1946, at 2:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 22, 1946 to Dec. 23, 1946 and that I last saw him alive on December 23, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Mar. 1 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben M. Ruman, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 12-23-46

2-25

2-740-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Dist. No. 11933 796

VS A15 .9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 yrs 2 mo 18 da
Hospital, institution, or street address where death occurred: Spring field State Hospital
How long in hospital or institution? 24 yrs 2 mo 18 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Annie Bond.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Sept 22 1864

8. AGE: Years 82 | Months 3 | Days 7 | If less than one day: hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: housework

11. Industry or business: home

FATHER
12. Name: John Bond
13. Birthplace: Md

MOTHER
14. Maiden name: Anna Chew Hobbs
15. Birthplace: Md

16. Informant: Mrs C Edward Miller
Address: 29 N Bellona Ave Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 31-1946 (month) (day) (year)
Cemetery or crematory: London Park
Location: Balto Md
18. Funeral director: Bertram Fore
Address: 2234 N Charles St

19. Jan 31 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 29th 1946, at 2.40 P M

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from Dec 11th 1922, to Dec 29 1946
and that I last saw h.. alive on Dec 29 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 da
Due to	
Due to Chronic Arterio Sclerosis	20 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: H H Haslup MD M. D. or other
Address: Sykesville Md Date signed 1/29/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Diat. No. 11933 760

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 110 E. Green
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Henry Bond

3. (b) Social Security Number 216-03-5641

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Margaret Ammond 6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Jan. 30 — 1876

8. AGE:

Years	Months	Days	If less than one day
70	10	15	...hrs. ...min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name William H. Bond
13. Birthplace Md.
MOTHER 14. Maiden name Margaret Buckingham
15. Birthplace Md.
16. Informant Margaret Bond
Address 110 E Green St, Westminster Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 18-1946 (month) (day) (year)
Cemetery or crematory Meadowbranch Cem.
Location Westminster, Md.
18. Funeral director H Bankard & Son
Address Westminster, Md.
19. 12/17 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 19 46, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ..., to ... 19 ...
and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Arteriosclerotic C-V disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE James T. Monroe M. D. or other
Address Westminster Md Date signed 12/17/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11934 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residance of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1408 School Street
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME
Alberta Moon Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife Charles Brown
6.(c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) Oct., 17, 1924

8. AGE:

Years	Months	Days	If less than one day
22	1	26	....hrs. ....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Dorsey Moon
13. Birthplace Georgia

MOTHER
14. Maiden name Lehency Moon
15. Birthplace Georgia

16. Informant Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-17-46 (month) (day) (year)
Cemetery or crematory Mt. Auburn
Location Baltimore, City.

18. Funeral director Geo. L. Kelson
Address 1303 Presstman. St.

19. 12/13 19 46 (Date rec'd by registrar) Albert R. Lansdale Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec., 13, 1946 at 4.45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov., 25, 1946 to Dec., 13, 1946 and that I last saw her alive on Dec., 13, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben W. Freeman, M.D. M. D. or other
Address Henryton, Md. Date signed 12/13/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; correct age is especially important. Physicians: please write the causes of death clearly and fully.

VS A15 9-45-15M

1-25

2-740 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

11935

Reg. Diat. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 2 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1½ Miles Out on Hoods Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles G. Brown

3.(b) Social Security Number: 220-09-8395A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Mary Hawk Brown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 30, 1873

8. AGE: Years: 73 | Months: 4 | Days: 13 | If less than one day: hrs. min.

9. Birthplace: Carroll Co. Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Sylvester Brown
13. Birthplace: Md.

MOTHER
14. Maiden name: Elizabeth C. Brown Myers
15. Birthplace: Md.

16. Informant: Sterling Helwig
Address: Westminster Md.

17. Burial (Burial, cremation, or removal, which?) Date thereof: 12/15/46 (month) (day) (year)
Cemetery or crematory: Fuhrers Cemetery
Location: near Westminster Md.

18. Funeral director: J. E. Myers Jr.
Address: Westminster Md.

19. 12/14 1946 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 13 1946, at 11-A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Gunshot Wound to Chest	
Due to	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 12-13-46
Where did injury occur? Mt Airy (City or town) Carroll (County) Md (State)
Injured at home, farm, industry, public place (where?): Farm
Means of injury: Hand by Self Injured at work? No

23. SIGNATURE: James T. Monk, Deputy Medical Examiner M. D. or other
Address: Westminster Md. Date signed: 12/14/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11936

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs. 1 mo., 27 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1922 McCulloh Srreet
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: RUTH F. BUNDY

3.(b) Social Security Number: 220-22-7477

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
famale	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 31, 1913

8. AGE: Years	Months	Days	If less than one day
33	6	25	hrs. min.

9. Birthplace: Lancaster, Va.
(Town, county, and state)

10. Usual occupation: Worker in Canning Factory

11. Industry or business:

FATHER
12. Name: Carry Bundy
13. Birthplace: Lancaster, Va.

MOTHER
14. Maiden name: Odelia Hall
15. Birthplace: Lancaster, Va.

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 30 - 1946 (month) (day) (year)
Cemetery or crematory Mt. Calvary Cemetery
Location Brooklyn
18. Funeral director Jas Brooks Ruggels
Address 1463 N. Carey St

19. 12/26 (Date rec'd by registrar) 19 46 Albert R. Grantham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 26, 19 46 at 9.00P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 29, 19 43 to Dec., 26, 19 46 and that I last saw her alive on December 26, 19 46

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Aug. 1943
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Rebecca W. Kinnan M.D. M. D. or other
Address: Henryton, Md. Date signed 12/26/46.

1-25

2-740- 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC

11937 744

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 12 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)

Street No.: 1821 Whitemore Avenue (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: GEORGE BYERS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: none

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 13, 1911(?)

8. AGE: Years	Months	Days	If less than one day
35	5	8	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER

12. Name: John Byers

13. Birthplace: Germany

MOTHER

14. Maiden name: Rosina Schmidt

15. Birthplace: Germany

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12-22-46 (month) (day) (year)

Cemetery or crematory:

Location: Balto. Md.

18. Funeral director: Williams Cook, Inc.

Address: 1217 E. Paul St.

19. Dec 22 1946 (Date rec'd by registrar) C. Henry Zilers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 21 1946, at 1:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 1941, to Dec. 21 1946 and that I last saw h...m alive on Dec. 21 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	over 2 months
Due to:	
Due to:	
Other conditions: Dementia Praecox-Hebephrenic type	12 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D. (M. D. or other)

Address: Springfield State Hosp. Sykesville, Md. Date signed 12-21-46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11938 Reg. Dist. No. 560

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 297 E. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Mary E. Chrest

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

B.(b) Name of husband or wife: Edward A. Chrest

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 4, 1870

8. AGE: Years	Months	Days	If less than one day
76	1	17	..... hrs. ..... min.

9. Birthplace: Westminster, Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: Lewis Schweigart

13. Birthplace: Maryland

MOTHER 14. Maiden name: Emily Mourer

15. Birthplace: Maryland

16. Informant: Edward N. Chrest

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 12/24/46 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 12/21 19 46 H. H. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 21 19 46 at 3:45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 33, to Dec. 21st 19 46 and that I last saw h.r. alive on Dec. 20th 19 46

Immediate cause of death	DURATION
Coronary Disease	attacks past 12 years.
Due to arterio-sclerosis	
Due to	
Other conditions Acute respiratory infection	10 days

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. T. Billingslea, M.D.
M. D. or other

Address: Westminster, Md. Date signed 12-21-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11939

Reg. Dist. No. 8-20

1. PLACE OF DEATH:

County: Carroll

City or town: Rural--Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural--Mt. Airy, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: ALVIN F. CONAWAY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name ~~of husband or~~ wife: Bessie A. Conaway

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Jan. 17, 1870

8. AGE: Years	Months	Days	If less than one day
76	11	9	...hrs. ...min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: William Conaway
13. Birthplace: Maryland

MOTHER
14. Maiden name: Clemetine Penn
15. Birthplace: Maryland

16. Informant: Mrs. Bessie A. Conaway
Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 12-28-46 (month) (day) (year)

Cemetery ~~or crematory~~: Pine Grove

Location: Mt. Airy, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. Dec 27 (Date rec'd by registrar) 19 46 Thos. D. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 26 1946, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 26 1946 to Dec 26 1946 and that I last saw h~~im~~ alive on Dec 25 1946

Immediate cause of death	DURATION
Acute Cardiac Failure	
Due to Chronic Hypertension with General Debility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. M. Waltz Poole M. D. ~~or other~~

Address: Mt. Airy Md. Date signed 12-26-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 74 — 11940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Rural - Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Reuben Cook

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col.	Married

6.(b) Name of husband or wife: Lydia Cook

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 4, 1881

8. AGE: Years	Months	Days	If less than one day
65	5	0	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Day Laborer

11. Industry or business

FATHER — 12. Name: Warner Cook

FATHER — 13. Birthplace: York.

MOTHER — 14. Maiden name: Mary Jane — York.

MOTHER — 15. Birthplace: York.

16. Informant: Lydia Cook

Address: Sykesville, Md. R.D. #1

17. Burial. (Burial, cremation, or removal (which)) Date thereof 12 6 46 (month) (day) (year)

Cemetery or crematory: White Rock

Location: Berrett, Carroll Co. Md.

18. Funeral director: C. M. Welty Jr.

Address: Winfield Md.

19. Dec. 5 1946 C. Henry Ward Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3 1946, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death:	
Coronary Occlusion	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James T. Shook Deputy Medical Examiner M. D. or other

Address: Westminster Md. Date signed 12/8/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

11941

Reg. Diat. No. 828

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Woodbine.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Woodbine.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war World War #2

3.(a) FULL NAME Roland W. Crabb

3.(b) Social Security Number 220-01-1842

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of ~~husband~~ or wife Ida May

6.(c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1909

8. AGE:

Years	Months	Days	If less than one day
37	3	19	...hrs. ...min.

9. Birthplace Howard County Maryland
(Town, county, and state)

10. Usual occupation Laborer.

11. Industry or business

FATHER 12. Name Herbert Crabb.

13. Birthplace Maryland.

MOTHER 14. Maiden name Rosie I. Wetzel.

15. Birthplace Maryland.

16. Informant Mrs Ida May Crabb.
Address Woodbine, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 23, 1946 (month) (day) (year)

Cemetery or ~~crematory~~ Poplar Springs

Location Poplar Springs

18. Funeral director C. M. Welty Jr.

Address Winfield Md

19. Dec. 22, 1946 (Date rec'd by registrar) Thos D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1946, at 6:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 19 1946, to Dec 20, 1946 and that I last saw h...im alive on December 19 1946

	DURATION
Immediate cause of death Hemic pleurisy (right)	2 da
Due to Hypertension	unknown
Due to Chr. Nephritis (type?)	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J Stanley Grabill M.D. or other

Address Mt Airy - Md Date signed 12/22/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11942

Reg. Dist. No. 760

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and forcibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll Co.
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. 4 mo.
Hospital, institution, or street address where death occurred: East Main St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: E. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Eliza Beddle Deacon

3. (b) Social Security Number:

4. Sex: F.
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: J. Herbert Deacon
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jan. 18. 1867
8. AGE: Years: 79 Months: 11 Days: 7 If less than one day: hrs. min.
9. Birthplace: Columbus Burlington Co. N.J. (Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business:
FATHER 12. Name: Joseph W. Beddle
13. Birthplace: N.J.
MOTHER 14. Maiden name: Charlotte B. Black
15. Birthplace: N.J.
16. Informant: Mrs. William E. Roch
Address: E. Main St. Westminster Md.
17. Burial (Burial, cremation, or removal. Which?) Manefield Date thereof: 12 (month) 27 (day) 46 (year)
Cemetery or crematory: Manefield Cemetery
Location: Columbus, New Jersey
18. Funeral director: J. E. Myers
Address: Westminster, Md.
19. 12/26/46 (Date rec'd by registrar) H. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25 1946, at 11-A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 30 1946, to December 25 1946 and that I last saw h.. alive on December 24 1946

	DURATION
Immediate cause of death: Arteriosclerotic C-V disease	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James T. Monroe M.D. M. D. or other
Address: Westminster Md. Date signed: 12/26/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

11943

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Keysville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Keysville

(If outside city or town limits, write RURAL and give nearest t

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Emma C. Devilbiss

3.(b) Social Security Numb: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William H. Devilbiss

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 19, 1864

8. AGE: Years	Months	Days	If less than one day
81	11	27	..... hrs. ..... min.

9. Birthplace: Carroll county Md.
(Town, county, and state)

10. Usual occupation: housework

11. Industry or business

FATHER

12. Name: James Robinson

13. Birthplace: England

MOTHER

14. Maiden name: Margaret Houx

15. Birthplace: Md.

18. Informant: Mrs. Roy E. Duble

Address: Keysville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof December 18, 1946 (month) (day) (year)

Cemetery or crematory: Keysville Cemetery

Location: Keysville, Md.

18. Funeral director: C.O.Fuss & Son

Address: Taneytown, Md.

19 Dec. 18, 1946 (Date rec'd by registrar) Ethel M Mackey Registrar

MEDICAL CERTIFICATION 1:45 P.M.

20. DATE OF DEATH: Dec. 16, 1946, at ...

21. I CERTIFY that death occurred on the date above stated; that I attended deceased t
Nov. 8 1946, to 12/16/46
and that I last saw h[illegible] alive on 12/16/46

Immediate cause of death
Bronchopneumonia 2 days
Type Undetermined
Due to Pulmonary edema and
acute bronchitis 4 days

Due to

Other conditions Hypostatic pneumonia and
Arteriosclerosis. Chronic alcoholism Addict
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statist

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (Sta

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. S. McVaugh M.D.
M. D. or oth

Address: Taneytown, Md. Date signed 12/17/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11944

Reg. Dist. No. 740

1. PLACE OF DEATH: Carroll

County

City or town Springfield State Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 years, 3 months, 24 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 33 years, 3 months, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of motber)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1722 North Calvert Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Isabel Didier

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1883

8. AGE: Years	Months	Days	If less than one day
63	6	24	hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation practical nurse

11. Industry or business

FATHER
12. Name Eugene Didier
13. Birthplace Maryland

MOTHER
14. Maiden name Louise North
15. Birthplace Maryland

16. Informant Hospital record

Address Springfield State Hospital

17. Burial Date thereof Dec. 11, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Cathedral Cem.

Location Balto. Md.

18. Funeral director H. W. Means & Son

Address Calvert St. Balto. Md.

19. Dec 10 1946 C. Henry Wood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9, 1946 at 2.25 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 1942 to December 8 1946 and that I last saw her alive on December 8 1946

Immediate cause of death	DURATION
cancer of the stomach	8 months
Due to	
Due to	
Other conditions Schizophrenia, paranoid type.	34 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Irene Hohman, M.D.
M. D. or other

Address Springfield State Hospital Date signed 12-9-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

11945 820

Reg. Dist. No. 183

1. PLACE OF DEATH:

County: Carroll

City or town: Mt. Olive
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Mt. Olive
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural-- Mt. Airy, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: GEORGE V. DORSEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of ~~husband or~~ wife: Cordelia Dorsey

6.(c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): ????????

8. AGE: Years: 83 ? | Months: | Days: | If less than one day: ....hrs. ....min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: Farm Laborer

11. Industry or business:

FATHER
12. Name: Not Known
13. Birthplace:

MOTHER
14. Maiden name: Lydia Dorsey
15. Birthplace: Maryland

16. Informant: Mrs. Cordelia Dorsey
Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof: 1-2-47 (month) (day) (year)

Cemetery ~~or crematory~~: Mt. Zion

Location: near Mt. Airy, Maryland

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. Jan 2 1947 (Date rec'd by registrar) Wm D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 31, 1946, at 6:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 8 1946, to Dec 31 1946 and that I last saw h... alive on Dec 26 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Hypertension and Chron.	
Due to Arteritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. M. Van Poole

Address: Mt Airy Md M. D. or other

Date signed: 12/31/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

CERTIFICATE OF DEATH

★ 11946 (50)

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war World War I

3. (a) FULL NAME Glen Hoover

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife Bessie A. Hoover
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 3 - 1890

8. AGE: Years 56 | Months 4 | Days 10 | If less than one day ..... hrs, ... min.

9. Birthplace Frederick County, Md
(Town, county, and state)

10. Usual occupation Farm Laborer

11. Industry or business

FATHER 12. Name Randolph Hoover
13. Birthplace Maryland

MOTHER 14. Maiden name Ordella Buckey
15. Birthplace Maryland

16. Informant Mrs. Bessie A. Hoover
Address New Windsor Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 16-46 (month) (day) (year)

Cemetery or crematory Winters Cemetery
Location New Windsor R. 1 Md

18. Funeral director H. W. Hartzler & Sons
Address Union Bridge & New Windsor Md

19. Dec 13 1946 (Date rec'd by registrar) Emma E Bright Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1946, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6 1946, to Dec 13 1946
and that I last saw him alive on Dec 13 1946

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to Bronchiectasis	
Bronchiectasis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE D. N. Leppo M. D. or other
Address Union Bridge Date signed 12-14-46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

11947

CERTIFICATE OF DEATH

Reg. Dist. No. 740

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mons., 28 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 2 mons., 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Pikesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 22 Clarendgden Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Austin Rudolph Dryden

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mrs. Edith Dryden

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): April 8, 1890.

8. AGE:

Years	Months	Days	If less than one day
56	8	18	...hrs. ...min.

9. Birthplace: Ireland
(Town, county, and state)

10. Usual occupation: Train conductor

11. Industry or business:

FATHER
12. Name: Rudolph Drydew
13. Birthplace: Md.

MOTHER
14. Maiden name: Ida Long
15. Birthplace: Md.

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-28-46 (month) (day) (year)

Cemetery or crematory: Emanuel Church Cem.

Location: Timonium Pike, Md.

18. Funeral director: H. H. Burgee

Address: 3631 Falls Rd. Balto. Md.

19. Dec 27 1946 (Date rec'd by registrar) C. Henry Kerr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 26, 1946, at 7:57a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 3, 1946, to Dec. 26, 1946 and that I last saw him alive on December 24, 1946

Immediate cause of death	DURATION
Chronic myocarditis and mycardial degeneration	6 yrs.
Due to	
Due to	
Other conditions: Psychosis with cerebral arteriosclerosis	6 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ...Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
M. D. or other

Springfield State Hospital
Sykesville, Maryland

Address: ...Date signed 12-26-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (54a)

CERTIFICATE OF DEATH

11948

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs 3 mo 7 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 8 yrs 3 mo 7 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto

City or town: Fullerton
(If outside city or town limits, write RURAL and give neerest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Lucian Edwards

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 3d - 1924

8. AGE:

Years	Months	Days	If less than one day
22	4	3	hrs. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Dependent

11. Industry or business:

FATHER
12. Name: Robert Edwards
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Dorsie Byrd
15. Birthplace: North Carolina

16. Informant: Robert Edwards
Address: Edgewood Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 12/46 (month) (day) (year)

Cemetery or crematory: Pennys Hall Methodist

Location: Penny Hall

18. Funeral director: Deans & Foster

Address: Belair, Md

19. Dec 11 1946 (Date rec'd by registrar) C. Henry Zickefoose Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 10th 1946, at 6-15a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1st 1946 to Dec 10th 1946 and that I last saw h... alive on Dec 10th 1946

Immediate cause of death	DURATION
Epilepsy	14 yrs
Due to	
Due to Post Operative Glioma of Brain	1931
Other conditions Removed	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. F. Wagstaff M.D.
M. D. or other

Address: Sykesville Md. Date signed: 12/10/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11949

Reg. Diat. No. 741

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 1801 W. Vine Street (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HARVY MILTON EPPS

3.(b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Loretta Epps
6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): May 2, 1905

8. AGE: Years	Months	Days	If less than one day
41	7	16	..... hrs. ..... min.

9. Birthplace: Wilmington, Del. (Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business:

FATHER
12. Name: Edward Epps
13. Birthplace: Delaware

MOTHER
14. Maiden name: Cora Stout
15. Birthplace: Maryland

16. Informant: Loretta Epps
Address: 1801 W. Vine Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 21 1946 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location:

18. Funeral director: Mrs. Katie B. Williams
Address: 322 N. Schroeder Street

19. 12/18 (Date rec'd by registrar) 19 46 Albert R. Grumbine Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 18, 1946 at 12.05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec., 14 1946 to Dec., 18 1946 and that I last saw him alive on December 18, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Herbert Hofman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 12/18/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-25

2-740 - 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

11950

Reg. Diat. No. 710

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Uniontown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Uniontown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Alverta Catharine Erb

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife -

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 30 1860

8. AGE:

Years	Months	Days	If less than one day
85	11	2	..... hrs. ..... min.

9. Birthplace Silversrum Carroll Co. Md.

(Town, county, and state)

10. Usual occupation Home

11. Industry or business

FATHER

12. Name Josiah Erb

13. Birthplace Carroll Co. Md.

MOTHER

14. Maiden name Rebecca Stonesifer

15. Birthplace Carroll Co. Md.

16. Informant Miss Lucretia Routson

Address Uniontown, Md.

17. Burial Date thereof Dec. 4-1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Methodist cemetery

Location Uniontown, Md.

18. Funeral director H. Bankard & Son

Address Westminster, Md.

19. Dec. 3 1946 Margaret R. England

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2 1946, at 3a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1946, to Dec 2 1946, and that I last saw h.. alive on Nov 30 1946

Immediate cause of death	DURATION
Senile Cardiac Disintegration	6 days
Due to Acute Pneumonia	4 days
Due to Arteriosclerosis	5 yrs.
Other conditions Chronic Hypertrophic Cirrhosis	3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, ferm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edward R. Fout M.D.

M. D. or other

Address Westminster Md. Date signed 12-3-46

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

11951 P

Reg. Dist. No. 740

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 5 mos 4 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs 5 mos 4 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Anna Furman (FORMAN)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

B.(b) Name of husband or wife: John

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 4 1880

8. AGE:

Years	Months	Days	If less than one day
56	4	16	hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Packing House Worker

11. Industry or business:

FATHER 12. Name: John White

13. Birthplace: Baltimore

MOTHER 14. Maiden name: Fannie White

15. Birthplace: Baltimore

18. Informant: Mrs. Helen Castrilli

Address: 216 W. Lakewood ave Balto

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec 28/46 (month) (day) (year)

Cemetery or crematory: Mt Lowell Mem Park

Location:

18. Funeral director: Philip Henry Lord

Address: 3024 Eutaw St

19. 12/26 1946 (Date rec'd by registrar) H. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 25th 1946 at 4 a m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 1944 to Dec 26 1946

and that I last saw h alive on Dec 26 1946

Immediate cause of death	DURATION
Cerebral hemorrhage, Ida	
Due to	
Due to Arterio Sclerosis	20 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. J. Waston M.D. M. D. or other

Address: Westminster Md. Date signed: 12/25/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53-a

CERTIFICATE OF DEATH

Reg. Dist. No. 11952 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 yrs 2 mo 13 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 34 yrs 5 mo 13 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Daisy Francis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1890

8. AGE: (56) Years: 56 Months: Days: If less than one day: hrs. min.

8. Birthplace: md. (Town, county, and state)

10. Usual occupation: dependent

11. Industry or business:

FATHER 12. Name: Robert Francis

13. Birthplace: Md

MOTHER 14. Maiden name: Mollie Wood

15. Birthplace: Md

16. Informant: Robert Francis

Address: 2200 Collington Ave Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-1-47 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. Jan. 1 1947 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 28th 1946, at 5.55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1946 to Dec 28 1946 and that I last saw h... alive on Dec 28 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 day
Due to:	
Due to:	
Other conditions: Epilepsy	40 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. H. Hastings M.D. M. D. or other

Address: Sykesville Md. Date signed: 12/28/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

11953

CERTIFICATE OF DEATH

Reg. Dist. No. 8-0

1. PLACE OF DEATH:
County: Carroll
City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: J. Walter Getty

3.(b) Social Security Number: none

4. Sex: male
5. Color or race: white
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Elsie Birely Getty
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): July 8 - 1871
8. AGE: Years: 75 Months: 4 Days: 23 If less than one day ..... hrs. ..... min.
9. Birthplace: Carroll County, Md (Town, county, and state)
10. Usual occupation: Retired Banker
11. Industry or business
FATHER 12. Name: Frank Getty
13. Birthplace: Maryland
MOTHER 14. Maiden name: Sarah Virginia Baile
15. Birthplace: Maryland
16. Informant: Mrs. Elsie B. Getty
Address: New Windsor, Md
17. Burial (Burial, cremation, or removal, Which?) Date thereof: Dec. 4-1946 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Frederick Md.
18. Funeral director: U. D. Hartzler & Sons
Address: Union Bridge & New Windsor, Md
19. Dec 4 1946 (Date rec'd by registrar) Emer Bixler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1 1946, at 5:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 4 1946 to December 1 1946 and that I last saw him alive on November 28 1946
Immediate cause of death: Generalized Arteriosclerosis — DURATION: years
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James T. Harrod M. D.
M. D. or other
Address: Westminster Md Date signed: 12-1-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11954

Reg. Dist. No. 74 1

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 24 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1033 Argyle Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HATTIE GREEN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife: Euris Green
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 21, 1924

8. AGE: Years	Months	Days	If less than one day
22	4	12	hrs. min.

9. Birthplace: Drewyville, Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Stephen Tilett
13. Birthplace: Virginia
MOTHER 14. Maiden name: Alice Joyner
15. Birthplace: Virginia
16. Informant: Deceased
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-8-46 (month) (day) (year)
Cemetery or crematory: Portsmouth,
Location: Virginia
18. Funeral director: Jno. F. Frances Undertaking Company.
Address: 548 W. Biddle St.
19. Dec. 3, 1946 (Date rec'd by registrar) Albert R. Swackhamer Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3, 1946 at 7:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 9, 1946 to Dec. 3, 1946 and that I last saw her alive on Dec. 3, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 12-3-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-740-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

11955 820

Reg. Dist. No. ....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Mt. Olive
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 51 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Mt. Olive
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural--Mt. Airy
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MARTHA ELIZABETH GRIMES

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: Charles F. Grimes
deceased
6.(c) If alive, give age: ....years

7. Birth date of deceased (mo., day, yr.): Oct. 11, 1872

8. AGE: Years 74 | Months 2 | Days 6 | If less than one day: ....hrs. ....min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: Elias Brandenburg
13. Birthplace: Maryland

MOTHER
14. Maiden name: Martha Welsh
15. Birthplace: Maryland

16. Informant: Mr. Marvin Grimes
Address: Mt. Airy, Maryland

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 12-20-46 (month) (day) (year)
Cemetery ~~or crematory~~: Taylorsville
Location: Taylorsville, Carroll Co. Md.

18. Funeral director: C.M. Waltz
Address: Winfield, Md.

19. Dec 19 1946 (Date rec'd by registrar) Wm D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 17 1946 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7 1946, to Dec 17 1946
and that I last saw h.. alive on Dec 17 1946

	DURATION
Immediate cause of death: Uremic Poisoning	
Due to: Cardiac Ascites	
Due to: Chronic Myocarditis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: .... Injured at work?

23. SIGNATURE: C. M. Van Poole M.D.
M. D. ~~or other~~
Address: Mt Airy Md Date signed 12/18-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11956

Reg. Dist. No. 74 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 1 month, 21 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 531 Wilson Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: PAULINE HARRIS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 12, 1903

8. AGE:	Years	Months	Days	If less than one day
	42	11	21	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business

FATHER
12. Name: Robert Harris
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Maggie Cooper
15. Birthplace: Baltimore, Md.

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/6/1946 (month) (day) (year)
Cemetery or crematory: Arbutus
Location: Baltimore County
18. Funeral director: Mrs Robert Elliott daughter
Address: 1129 N. Caroline St.

19. Dec. 3, 1946 (Date rec'd by registrar) Albert R. Grantham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3, 1946, at 10:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 12, 1945 to Dec. 3, 1946 and that I last saw her alive on Dec. 3, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Nelson W. Swan, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 12-3-46

1-25

2-740 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

11957

CERTIFICATE OF DEATH

Reg. Dist. No. 740

1. PLACE OF DEATH:

County Carroll

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Carroll

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Margaret D. Hatfield

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widowed

6.(b) Name of husband or wife James C. Hatfield

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 27, 1850

8. AGE: Years	Months	Days	If less than one day
96	7	17	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name Terrence Dowd

13. Birthplace Ireland

MOTHER 14. Maiden name Catherine Farley

15. Birthplace Ireland

16. Informant Miss Bertha Hatfield

Address Sykesville, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Dec. 16, 1946 (month) (day) (year)

Cemetery or crematory Springfield Cemetery

Location Sykesville, Md.

18. Funeral director C. Harry Wees

Address Sykesville, Md.

19. Dec. 16 1946 (Date rec'd by registrar) C. Harry Wees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1946, at 10.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935 19..., to death 19... and that I last saw h.er alive on Dec. 14 1946

Immediate cause of death	DURATION
Chronic myocarditis	
Due to hypertensive cardiovascular disease with arteriosclerosis	
Due to Senility.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. H. Lawrence M.D. M. D. or other

Address Sykesville Md. Date signed 12/14/46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1625)

CERTIFICATE OF DEATH

Reg. Dist. No. 11958 7 40 (Bc)

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mon. 15 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 8 mon. 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Edward Valentine Henry, Senior

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Sarah R. Henry

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 18, 1862

8. AGE:

Years	Months	Days	If less than one day
84	10	24	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Trumpet Player

11. Industry or business:

FATHER — 12. Name: William Henry

13. Birthplace: Baltimore Md

MOTHER — 14. Maiden name: Ann Clement

15. Birthplace: Baltimore Md.

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 5, 1946 (month) (day) (year)

Cemetery or crematory: Baltimore Cemetery

Location: North Ave & Rose Streets 13

18. Funeral director: Albert L. Hilt Jr.

Address: 1606 N Chester Street

19. 12-4 19 (Date rec'd by registrar) Registrar

1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 2, 1946, at 3:25p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13, 1946, to Dec. 2, 1946 and that I last saw him alive on December 2 1946

Immediate cause of death	DURATION
Senility	1 yr.
Due to	
Due to	
Other conditions: Senile psychosis, depressed type (Include pregnancy within 3 months of death)	1 yr.

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D., M.D. or other

Springfield State Hospital
Address: Sykesville, Maryland Date signed: 12-2-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11959

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 month, 6 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton, Maryland.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)
Street No. 650 Pennsylvania Avenue (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: BERNICE CORNELIA HILL

3. (b) Social Security Number: 215-20-8876

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: John Hill
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): February 25, 1923

8. AGE: Years	Months	Days	If less than one day
23	9	16	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Walter Campher
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Catherine Jones
15. Birthplace: Hampton, Va.

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-14-1946 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Md.
18. Funeral director: William H. Downey
Address: 241 E. Frederick St. Hagerstown Md.
19. 12/11 (Date rec'd by registrar) 19 46 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 11, 1946 at 12.45A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5, 1946 to Dec., 11, 1946 and that I last saw her alive on December 11, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Reuben W. Ruan, M.D. (M. D. or other)
Address: Henryton, Md. Date signed 12/11/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-75

2-7740 - 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

11960

Reg. Dist. No. 740

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jacqueline Etta Hobbs

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1938

8. AGE:

Years	Months	Days	If less than one day
8	10	19	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual occupation Scholar
11. Industry or business At School
FATHER 12. Name W. Allen Hobbs
13. Birthplace Md.
MOTHER 14. Maiden name Esther Gaither
15. Birthplace Md.
16. Informant Mrs. W. Allen Hobbs
Address Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 8 1946 (month) (day) (year)
Cemetery or crematory Springfield Cemetery
Location Sykesville, Md.
18. Funeral director C. Harry Wiley
Address Sykesville, Md.
19. Dec. 7 1946 (Date rec'd by registrar) C. Harry Wiley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6th 1946, at 12 Noon M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on Dec. 6th 1946
Immediate cause of death Crushed Skull, crushing injuries to extremities and abdomen. — DURATION: Few moments
Due to
Due to Run over by truck
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 12-6-46
Where did injury occur? Springfield (City or town) Carroll (County) Md. (State)
Injured at home, farm, industry, public place (where?) Springfield Ave. Injured at work?
Means of injury Truck

23. SIGNATURE W. Billingslea, Md. Acting Deputy Md. C.M.E. M. D. or other
Address Sykesville, Md. Date signed 12-6-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1196 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor Rural #2
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: near Taylorsville
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Margaret L Slater Horton

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Wm A. Horton

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 16- 1878

8. AGE:

Years	Months	Days	If less than one day
68	4	5	____ hrs. ____ min.

9. Birthplace: Carroll County, Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER
12. Name: Not Known
13. Birthplace

MOTHER
14. Maiden name: Not Known
15. Birthplace

16. Informant: Wm A. Horton
Address: New Windsor Md. R. D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 24- 1946 (month) (day) (year)

Cemetery or crematory: Methodist Cemetery

Location: Taylorsville, Md.

18. Funeral director: C. A. Hartzler & Sons

Address: Union Bridge & New Windsor, Md

19. Dec 22 1946 (Date rec'd by registrar) E. M. Formwalt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 21 1946 at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 14 1946 to Dec 21 1946 and that I last saw h[illegible] alive on Dec 20 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	12/14/46
Due to: Hypertension	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ____ Injured at work?

23. SIGNATURE: C. M. Van Poole M. D. or other

Address: Mt Airy Md Date signed: 12/22/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

11962

Reg. Dist. No. 240

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 15 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 4 months, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Third Street, Woodlawn, Lavale
(If rural, give LOCATION)

2.(a) If veteran, name war: /

3.(a) FULL NAME: Dora LaVoda Hughes

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 8, 1896

8. AGE: Years	Months	Days	If less than one day
50	1	15	..... hrs. ..... min.

9. Birthplace: Allegany County, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: William Eisel
13. Birthplace: Allegany County, Maryland

MOTHER
14. Maiden name: Annie Offman
15. Birthplace: Allegany County, Maryland

16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal, Which?) Date thereof: 12-26-46 (month) (day) (year)

Cemetery or crematory: Will Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Dec. 23 1946 (Date rec'd by registrar) C. Harry Mills Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/23 19 46 at 9:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/8/46 19 to 12/23 19 46 and that I last saw her alive on 12/23 19 46

Immediate cause of death	DURATION
Coronary Thrombosis	Instant
Due to: Fronlin stock	2 hours.
Due to:	
Other conditions: Involutional Psychosis, agitated depression (Include pregnancy within 3 months of death)	7 mos.

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. M. D. or other

Address: Springfield State Hospital Sykesville, Md. Date signed: 12/23/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11963

Reg. Dist. No. 940

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 10 mos., 1 day

Hospital, institution, or street address where death occurred:
Springfield Sate Hospital

How long in hospital or institution? 1 yr., 10 mos., 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 135 S. Liberty St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: FLICK JOHN KERNS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): (mo, day unknown) 1905

8. AGE: Years	Months	Days	If less than one day
41			..... hrs. ..... min.

9. Birthplace: Evenwood, W. Va.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ------

FATHER
12. Name: Luther Kerns
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Zoey Warner
15. Birthplace: West Virginia

16. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-24-46 (month) (day) (year)

Cemetery or crematory: Zion Memorial Cemetery

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. DEC 22 1946 (Date rec'd by registrar) C. Henry Ware Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 21, 1946, at 11:59 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 20, 1945, to Dec. 21, 1946 and that I last saw him alive on Dec. 21, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 mos.
Due to:	
Due to:	
Other conditions: Schizophrenia, Hebephrenic type. (Include pregnancy within 3 months of death)	14 yrs.

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D.
M. D. or other

Address: S. S. Hosp., Sykesville, Md. Date signed: 12-22-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1702)

CERTIFICATE OF DEATH

11964

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Freemount Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pa County:

City or town: Gettysburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 80 S Lemmon Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Rhoda H. Koontz

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	M.

6.(b) Name of husband or wife: Allen Koontz

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 10 - 1900

8. AGE: Years	Months	Days	If less than one day
36	5	16	hrs. min.

9. Birthplace: Adams Co Penna (Town, county, and state)

10. Usual occupation: Waitress

11. Industry or business: Restaurant

FATHER — 12. Name: Johnson Jacobs

FATHER — 13. Birthplace: Adams Co. Pa

MOTHER — 14. Maiden name: Emma Gallagher

MOTHER — 15. Birthplace: Washington D.C.

16. Informant: J Milton Bender

Address: Gettysburg Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-26-46 (month) (day) (year)

Cemetery or crematory: Evergreen Cemetery

Location: Gettysburg, Pa

18. Funeral director: J Milton Bender

Address: Gettysburg Pa

19. Dec. 26 1946 (Date rec'd by registrar) John L. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 25 1946, at 11:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19— to — 19—

and that I last saw h— alive on — 19—

Immediate cause of death	DURATION
Fracture Cervical Vertebrae	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 12-25-46

Where did injury occur? Freemount (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Auto accident Injured at work? No

23. SIGNATURE: [signature] M. D. or other

Address: Westminster Md Date signed: 12-26-46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-L)

CERTIFICATE OF DEATH

11965

Reg. Diat. No. 74

BC

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs 3 mo 6 da

Hospital, Institution, or street address where death occurred: Spring field State Hospital

How long in hospital or institution? 18 yrs 3 mo 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: [illegible]

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Herman Lankes

3. (b) Social Security Number

4. Sex	5. Color or race	6.(d) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If wife, give age: years

7. Birth date of deceased: July 29 1886

8. AGE: Years 60 | Months 4 | Days 14 | If less than one day: hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Grocery Clerk

11. Industry or business: Grocery

FATHER 12. Name: Hammond Lankes

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Clementine Gadyum

MOTHER 15. Birthplace: 126 Poplar St Balto

16. Informant:

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof DEC 16 1946 (month) (day) (year)

Cemetery or crematory: Westview

Location: Baltimore

18. Funeral director: Frederick A Cole

Address: 1200 W Lombard St.

19. 12/16 19 46 (Date rec'd by registrar) A. C. Hebert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 13th 1946 at 6-15 A M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Sept 6th 1938 to Dec 13 1946 and that I last saw h. alive on Dec 12 1946

Immediate cause of death	DURATION
Chronic Hypertension	20 yrs
Due to:	
Due to: Epilepsy	40 yrs
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. F. Masten M. D. or other

Address: Sykesville Md Date signed: 12/13/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-a)

CERTIFICATE OF DEATH

11966

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 30 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. Balto. Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Helen Cole Lockard

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife James A. Lockard
6.(c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) July 10

8. AGE: Years	Months	Days	If less than one day
76	4	21	hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Home - wife
11. Industry or business

FATHER
12. Name Jesse Magee
13. Birthplace Md.

MOTHER
14. Maiden name Elmira Cole
15. Birthplace Miss?

16. Informant Mrs. James A. Lockard
Address Westminster Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/3/46 (month) (day) (year)
Cemetery or crematory Bethel Cemetery
Location Carrollton
18. Funeral director J. E. Myers, Jr.
Address Westminster Md.
19. 12 4 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1st 1946, at 1 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about 10 1946, to December 1st 1946
and that I last saw h[er] alive on December 1st 1946

	DURATION
Immediate cause of death	
Cerebral Embolism & Hemorrhage	24 hrs.
Due to Chr. Interstitial Nephritis	6 yrs.
Due to	
Other conditions Chr. Paralysis Agitans	15 years

(Include pregnancy within 3 months of death)

Major findings at operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Hector Bon (M.D.)
M. D. or other
Address Westminster Md. Date signed 12/2/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11967

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 13 S. Bond Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: IRENE LUCAS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 11, 1922

8. AGE: Years	Months	Days	If less than one day
24	4	20	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER 12. Name: Daniel Lucas

13. Birthplace: Petersburg, Va.

MOTHER 14. Maiden name: Bertha Winters

15. Birthplace: Redding, Pa.

16. Informant: Catherine Lucas (Sister)

Address: 14 S. Bond St., Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/2/47 (month) (day) (year)

Cemetery or crematory: Mt Calvery

Location: Brooklyn Md

18. Funeral director: Brady-Wilson

Address: 10008 Harford Ave

19. Dec. 31, 1946 (Date rec'd by registrar) Albert R. Smallhamer Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 31, 1946 12:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 23, 1946, to Dec. 31, 1946 and that I last saw her alive on Dec. 31, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1, 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other

Address: Henryton, Md. Date signed 12-31-46.

1-25

2-740 - 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11968 P

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years 1 month 11 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 3 years 1 month 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 3229 E. Baltimore St. (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Sebastian John Lucas

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Marie Lucas
6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): May 2, 1902

8. AGE: Years	Months	Days	If less than one day
44	6	29	hrs. min.

9. Birthplace: Baltimore City, Maryland (Town, county, and state)
10. Usual occupation: Sheet metal worker
11. Industry or business: Building construction

FATHER
12. Name: Ambrose F. Lucas
13. Birthplace: Maryland

MOTHER
14. Maiden name: Frances Chloda
15. Birthplace: Maryland

16. Informant: Springfield State Hosp Records
Address: Sylesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 4, 1946 (month) (day) (year)
Cemetery or crematory: Holy Redeemer Cem
Location: Balto. Md.
18. Funeral director: Philip Stewig Sons
Address: 2024 Orleans St.

19. 12-2 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1 1946, at 8:52A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 1946, to Dec. 1 1946
and that I last saw him alive on November 30 1946

Immediate cause of death	DURATION
Chronic nephritis	3 years
Due to	
Due to	
Other conditions: Schizophrenia	3 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Howard N. Fredericksen M.D. M. D. or other
Address: Sykesville, Md. Date signed: 12/1/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (130)

CERTIFICATE OF DEATH

11969

Reg. Dist. No. 760

1. PLACE OF DEATH:

County Carroll

City or town 160 W. Main St. Westminster, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Keymar
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Emma Susan Lynn

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Guy B. Lynn

6.(c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) May 15, 1868

8. AGE:

Years	Months	Days	If less than one day
78	7	15	...hrs. ...min.

9. Birthplace Johnsville, Frederick Co. Md.
(Town, county, and state)

10. Usual occupation housework

11. Industry or business

FATHER
12. Name Jacob Bostian
13. Birthplace Md.

MOTHER
14. Maiden name Sarah Eyler
15. Birthplace Md.

16. Informant Mrs. J. Earl Lynn

Address 160 W. Main Street, Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 2, 1946 (month) (day) (year)

Cemetery or crematory Baughman's Cemetery

Location Ladiesburg, Md.

18. Funeral director C. O. Fuss & Son

Address Taneytown, Md.

19. 12/30/46 (Date rec'd by registrar) D. K. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30th 1946 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 14th 1946, to Dec 30 1946

and that I last saw h. alive on Dec 30, 1946

Immediate cause of death	DURATION
acute myocarditis	3 days
Due to acute interstitial nephritis	16 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. R. Fout, M.D. M. D. or other

Address Westminster Md. Date signed 12-31-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

11970

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3 Dupont Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: John James Maddox

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
58	?	?		

9. Birthplace: Montgomery County, Maryland
(Town, county, and state)

10. Usual occupation: Farmer--Grocer

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Montgomery County

MOTHER
14. Maiden name: Unknown
15. Birthplace: Montgomery County

16. Informant: Records of Springfield State Hospital

Address: Sykesville, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12-2-46 (month) (day) (year)

Cemetery or crematory: Removal to

Location: Bethesda Md. Montgomery County

18. Funeral director: Wm. Reuben Funeral Dir.

Address: Bethesda, Md.

19. 12-2-1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1 1946 4:37 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 16 1946 to Dec. 1 1946 and that I last saw him alive on Dec. 1 1946

Immediate cause of death	DURATION
Chronic Myocarditis	unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: Chronic Myocarditis, Probable old brain abscess - purulent

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D.
M. D. or other

Address: S.S.H., Sykesville, Md. Date signed 12-1-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11971

Reg. Dist. No. 74 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 2 months, 20 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 1027 Peach Street (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES MALLORY

3.(b) Social Security Number: 218-23-3077

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 8, 1902

8. AGE: Years	Months	Days	If less than one day
44	11	1	hrs. min.

9. Birthplace: Beaver Dam, Va. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: James Mallory, Sr.
13. Birthplace: Beaver Dam, Va.

MOTHER
14. Maiden name: Gracie Henderson
15. Birthplace: Beaver Dam, Va.

16. Informant: Deceased
Address:

17. (Burial, cremation, or removal. Which?) Shipped Date thereof: Jan. 11, 1946 (month) (day) (year)
Cemetery or crematory: Burial
Location: Ashland Va.
18. Funeral director: W. H. Mahony
Address: Ashland Va.

19. 12/9 (Date rec'd by registrar) 19 46 Albert R. Lowman Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 9, 19 46 at 1.49 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept., 19 19 45 to Dec., 9, 19 46 and that I last saw him alive on Dec., 9, 19 46

Immediate cause of death: Pulmonary Tuberculosis — DURATION: July 1945

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Lucas, M. D. M. D. or other
Address: Henryton, Md. Date signed: 12/9/46

1-25

2-740-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24-d)

CERTIFICATE OF DEATH

11972

★ BC

Reg. Dist. No. 740

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykeaville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 yr., 8 mo., 22 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 48 yr., 8 mo., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Dennis McCarthy

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

6.(b) Name of husband or wife: Annie Sweeney

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unk 1857

8. AGE: Years: 89 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: railroad

FATHER — 12. Name: Dennis McCarthy

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Mary Coughlin

MOTHER — 15. Birthplace: Ireland

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-18-46 (month) (day) (year)

Cemetery or crematory: New Cathedral Cem.

Location: Balto. Md.

18. Funeral director: Flynn & Fleming

Address: 1426 Light St.

19. Dec. 17 1946 (Date rec'd by registrar) C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 15 1946, at 8:15A a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943, to December 15 1946 and that I last saw him alive on December 15 1946

	DURATION
Immediate cause of death: Senility	10 yrs.
Due to:	
Due to:	
Other conditions: Paranoid Condition	50 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.

M. D. or other

Springfield State Hospital

Address: Sykesville, Maryland

Date signed: 12-15-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (70-5)

CERTIFICATE OF DEATH

12564

Reg. Dist. No. 770

1. PLACE OF DEATH:

County: Carroll

City or town: Freemount Mst

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?: —

Hospital, institution, or street address where death occurred:

How long in hospital or institution?: —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pa County:

City or town: Gettysburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 12

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Joseph Edward McCaughlin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Married

6.(b) Name of husband or wife: Rosalie M McCaughlin

6.(c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): May 25 - 1915

8. AGE: Years: 31 | Months: 7 | Days: | If less than one day: hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business: Garage

FATHER — 12. Name: George McCaughlin

FATHER — 13. Birthplace: Penna

MOTHER — 14. Maiden name: Minnie Baldwin

MOTHER — 15. Birthplace: Penna

16. Informant: Mrs Jos E McCaughlin

Address: Bladensville Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-28-46 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Adams Co. Pa.

18. Funeral director: Edw C Tipton

Address: Hampstead Md.

19. Dec. 26 46 (Date rec'd by registrar) John S. Hughes Jr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25 1946, at 11:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Fractured Skull	
Cerebral Hemorrhage	
Due to: Fire - Auto Accident	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 12-25-46

Where did injury occur? Freemount Carroll Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Highway Rt 2

Means of injury: Auto Accident Injured at work? No

23. SIGNATURE: Louis T Shook Deputy Medical Examiner

M. D. or other

Address: Gettysburg Md Date signed: 12-26-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-C)

CERTIFICATE OF DEATH

11973

Reg. Dist. No. 760

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Rural R. D. 2
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural R. D. 2
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Winfield Franklin Miller

3. (b) Social Security Number: 219-12-2112

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name ~~of husband or~~ wife: Bertie Mae Miller
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 17 - 1879

8. AGE: Years: 67 | Months: 3 | Days: 24 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll County, Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: John Miller
FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Alice Piper
MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Bertie M. Miller
Address: Westminster, Md.

17. Buried
(Burial, cremation, or removal. Which?)
Date thereof: Dec. 14-1946
(month) (day) (year)
Cemetery or crematory: Meadow Branch Cem
Location: Westminster R. 6, Md.

18. Funeral director: C. H. Hartley & Sons
Address: Union Bridge & New Windsor, Md

19. 12/13/1946
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 11, 1946, at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1946, to Dec 11 1946
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
acute cardiac dilatation	6 hrs
Due to: Carcinoma of bladder	11 mos
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Chas. R. Fout M.D.
M. D. or other
Address: Westminster Md. Date signed 12-11-46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 11974 750

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Taneytown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Martha H. Mohney

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Harry M. Mohney

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 28, 1891

8. AGE: Years	Months	Days	If less than one day
55	6	26	hrs. min.

9. Birthplace: Evans City, Penna.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: George Stratton
13. Birthplace: Penna.

MOTHER
14. Maiden name: Elizabeth Maitland
15. Birthplace: Penna

16. Informant: Harry M. Mohney
Address: Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 26, 1946 (month) (day) (year)

Cemetery or crematory: Reformed Cemetery

Location: Taneytown, Md.

18. Funeral director: C.O.Fuss & Son

Address: Taneytown, Md.

19. Dec. 24 1946 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 24 1946 at 6 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 2 1946, to Dec 24 1946, and that I last saw h.. alive on Dec 22 1946

Immediate cause of death	DURATION
~~Diabetes~~	
Chronic Myocarditis	
Due to Diabetes Mel.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. N Legg M. D. or other

Address: Union Bridge Date signed: 12-24-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11975

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: 1815 N. Dallas Street (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: GILBERT MOSELY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 6, 1901

8. AGE: Years	Months	Days	If less than one day
45	11	25	hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Ship Yard Laborer

11. Industry or business:

FATHER — 12. Name: Edward Mosely

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Luvenia Stokes

15. Birthplace: Virginia

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/4/47 (month) (day) (year)

Cemetery or crematory:

Location: Alberta Va

18. Funeral director: Metropolitan Funeral Home Inc.

Address: 927 N. Front St.

19. Dec. 31, 46 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 31, 1946 at 8:40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 16, 1946, to Dec. 31, 1946 and that I last saw him alive on December 31, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben D. Kuman, M. D. (M. D. or other)

Address: Henryton, Md. Date signed: 12-31-46

1-25

2-740-1-10

11976

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137a)

CERTIFICATE OF DEATH

Reg. Diat. No. 770

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Hampstead
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 84 years.
Hospital, Institution, or street address where death occured:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Hampstead
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Richard E Murray.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married.

6.(b) Name of ~~husband~~ or wife: Ida Kate Bowers
6.(c) If alive, give age: 84 years

7. Birth date of deceased (mo., day, yr.): Oct 18 1862

8. AGE:

Years	Months	Days	If less than one day
84	2	5	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business
FATHER 12. Name: Ephriam Murray
13. Birthplace: Md
MOTHER 14. Maiden name: Caroline Wilhelm
15. Birthplace: Md
16. Informant: Mrs R. E Murray.
Address: Hampstead, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-26-46 (month) (day) (year)
Cemetery or crematory: Hampstead
Location: Carroll Co Md
18. Funeral director: Edw A Tipton
Address: Hampstead Md
19. Dec. 24 1946 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 23 1946 at 4:10a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1944 to Dec 23 1946 and that I last saw h.. alive on Dec. 22 1946

Immediate cause of death	DURATION
Uremia	2 weeks
Due to: Urinary Obstruction	8 mo
Due to: Prostatic Hypertrophy	3 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Marion C. Porterfield M. D. or other
Address: Hampstead, Md Date signed 12-24-46

1-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

11977

CERTIFICATE OF DEATH

Reg. Dist. No. 740

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5yrs. 11mo. 21da.

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 5yrs. 11mo. 21da.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster (If outside city or town limits, write RURAL and give nearest town)

Street No. 29 West Moreland Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: SARAH ROSENBERG

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE:	Years	Months	Days	If less than one day
Apparent	50			hrs. min.

9. Birthplace: Bridgeton--New Jersey (Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER
12. Name: David Rosenberg
13. Birthplace: Russia

MOTHER
14. Maiden name: Jeanette Wooloch
15. Birthplace: Poland

16. Informant: Hospital Records

Address: Sykesville, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-7-46 (month) (day) (year)

Cemetery or crematory: MISHKIN ISRAEL

Location: SOUTHERN AVE

18. Funeral director: Sol LEVINSON & BROS

Address: 1124-26 W NORTH AVE

19. Dec 5 (Date rec'd by registrar) 1946 C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5 1946, at 2:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14, 1942 to Dec. 5th 1946 and that I last saw her alive on Dec. 4th 1946

Immediate cause of death	DURATION
Tuberculosis of the Lungs	Reported Tb. 1-10-1941
Due to:	
Due to:	
Other conditions: Schizophrenia-Paranoid Type	32 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Hans M. Reese M.D. M. D. or other

Address: Sykesville Md. Date signed 12-5-46

11978

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One year.
Hospital, institution, or street address where death occurred:
Warfield's Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural - Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Warfield Nursing Home
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Brady W. Shipley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	widowed

6.(b) Name ~~of husband~~ or wife: Ruth A. Shipley deceased
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Aug. 9, 1859

8. AGE: Years: 87 Months: 4 Days: 17 If less than one day: hrs. min.

9. Birthplace: Frederick Co. Md. (Town, county, and state)
10. Usual occupation: Carpenter retired
11. Industry or business:
FATHER 12. Name: William Shipley
13. Birthplace: Md
MOTHER 14. Maiden name: Elizabeth Murphy
15. Birthplace: Md.
16. Informant: Mrs. Bessie Warner
Address: Westminster Md.
17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof: 12-28-46 (month) (day) (year)
Cemetery or ~~crematory~~: Jennings Chapel
Location: Florence Howard Co. Md.
18. Funeral director: C. M. Walts
Address: Winfield. Md
19. 12/26 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 26 1946 at 1:10 A. M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 1946, to Dec. 26 1946 and that I last saw h.. alive on Dec 24 1946

Immediate cause of death	DURATION
Arteriosclerotic C-V disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James T. Marsh M.D.
M. D. or other
Address: Westminster Md. Date signed: 12-26-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8-2)

CERTIFICATE OF DEATH

11979

Reg. Dist. No. 80

1. PLACE OF DEATH:
County: Carroll
City or town: Union Furnace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Finwood
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route 1
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Georgia Anna Shipley

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles E. Shipley
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): — 1890

8. AGE: Years: 56 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Not Known
13. Birthplace: Not Known

MOTHER
14. Maiden name: Not Known
15. Birthplace: Not Known

16. Informant: Charles E. Shipley
Address: Finwood Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 4/1946 (month) (day) (year)
Cemetery or crematory: Bethel Church Cemetery
Location: New Reese Md.
18. Funeral director: D. D. Hutton & Son
Address: Union Bridge & New Windsor Md.

19. Dec 4 1946 (Date rec'd by registrar) Ernest Bankert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1 1946 at 11.40 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 1 1946 to Dec 1 1946
and that I last saw h.. ex.. alive on Dec 1 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to (Blood pressure 276)	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: E. H. Legg M. D. or other
Address: Union Bridge Md. Date signed: 12-2-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

11980

Reg. Dist. No. 760

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll Co.
City or town: West Minister, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 62 years
Hospital, institution, or street address where death occurred: 43 E. Main St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: West Minister
(If outside city or town limits, write RURAL and give nearest town)
Street No. 43 E. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Jacob Walter Shumb

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	widowed

6.(b) Name of husband or wife: Maggie Elizabeth Anders
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 20, 1856

8. AGE: Years	Months	Days	If less than one day
90	3	3	hrs. min.

9. Birthplace: Middleburg Carroll Co. Md.
(Town, county, and state)
10. Usual occupation: Farmer - Miller
11. Industry or business:

FATHER
12. Name: Samuel Shumb
13. Birthplace: Middleburg Carroll Co. Md.

MOTHER
14. Maiden name: Catherine Hyter
15. Birthplace: Middleburg Carroll Co. Md.

16. Informant: Miss Marguerite Shumb
Address: 43 E. Main St. Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/26/46 (month) (day) (year)
Cemetery ~~or crematory~~: West Minister Cemetery
Location: Westminster Md.

18. Funeral director: D. E. Myers Jr.
Address: Westminster Md.

19. 12/24/46 (Date rec'd by registrar) D. E. Myers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 23 - 1946, at 3:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1946 to Dec 23 1946
and that I last saw him alive on Dec 23 - 1946

Immediate cause of death	DURATION
Nephritis (Chr)	
Myocarditis (acute)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. C. Jennette M.D.
M. D. or other
Address: Westminster Md. Date signed 12-24-46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

11981

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

BC

Reg. Dist. No. 74a

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs. 7 mon. 7 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 17 yrs. 7 mon. 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Herman Steiner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1874

8. AGE: Years: 72 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: Springfield State Hospital Records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 19 1946 (month) (day) (year)

Cemetery or crematory: Hebrew Mt Carmel Cem.

Location: Balto. Md.

18. Funeral director: Jack Lewis, Inc.

Address: 1439 E. Balto. St.

19. Dec. 18 1946 (Date rec'd by registrar) C. Harry Lewis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 17, 1946, at 7:30 p.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1943, to Dec. 17, 1946

and that I last saw him alive on December 17, 1946

	DURATION
Immediate cause of death: Coronary artery disease (infarction)	1 yr
Due to: Arteriosclerosis,	
more than	1 yr
Due to:	
Other conditions: Schizophrenia, hebephrenic type.	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
M. D. or other

Springfield State Hospital
Address: Sykesville, Maryland Date signed: 12-18-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

CERTIFICATE OF DEATH

11982

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Finksburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural Finksburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 1.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3. (a) FULL NAME: Walter H. C. Stocksdale

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

B.(b) Name of husband or wife: Dora V. Myers

9.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): July 25, 1884

8. AGE: Years	Months	Days	If less than one day
62	5	6	...hrs. ...min.

9. Birthplace: Finksburg, Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: John Thomas Stocksdale

13. Birthplace: Maryland

MOTHER

14. Maiden name: Mariah Muscoe

15. Birthplace: Maryland

16. Informant: Mrs Walter Stocksdale

Address: Finksburg, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 1/2/47 (month) (day) (year)

Cemetery or crematory: Providence Cemetery

Location: Gamber, Md.

19. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 1/2 (Date rec'd by registrar) 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 31, 1946, at 12.30 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 1944, to Dec 31 1946

and that I last saw h[illegible] alive on Dec 30 1946

Immediate cause of death	DURATION
Coronary occlusion	4 hrs.
Due to Arteriosclerosis	
Due to Myocardial degeneration,	
Due to Fr Valvular Insufficiency	4 yrs.
Other conditions Obesity	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [illegible] Speicher M. D. or other

Address: Westminster Md. Date signed 12/31/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

11983

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Finksburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Finksburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Elizabeth Ann Wilder

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Apr. 5, 1863

8. AGE:	Years	Months	Days	If less than one day
	83	8	23	____ hrs. ____ min.

9. Birthplace Catasauqua, Carroll Co., Md.
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business Home
FATHER 12. Name Geo. Washington Wilder
13. Birthplace Maryland
MOTHER 14. Maiden name Mary Ann Slater
15. Birthplace Maryland
16. Informant Alice J. Wilder
Address Finksburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-30-46 (month) (day) (year)
Cemetery or crematory Lady Mount
Location Carroll Co. Md.
18. Funeral director Edelen & Tipton
Address Hampstead Md.
19. 12/28 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1946, at 6.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 12 1944 to Dec 28, 1946 and that I last saw h.. alive on Dec 27, 1946

Immediate cause of death	DURATION
Chronic Myocarditis	2 yrs
Due to	
Due to	
Other conditions Carcinoma of Rectum	2

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Edgar M. Bush M.D.
M. D. or other
Address Hampstead, Md. Date signed 12/28/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

11984

Reg. Dist. No. 700

1. PLACE OF DEATH:

County Carroll

City or town Taneytown District
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Littlestown, PA R.D. 1

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 36 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll R.D.1.

City or town Littlestown PA Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Taneytown District
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Silas Kelly Utz

3. (b) Social Security Number None

4. Sex Male | 5. Color or race White | 6.(a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ida (Erchison) Utz

6(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Jan - 8 - 1872

8. AGE: Years 74 | Months 11 | Days 11 | If less than one day ____ hrs. ____ min.

9. Birthplace Frederick County Md.
(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business Farming (Retired)

FATHER 12. Name Samuel H. Utz

FATHER 13. Birthplace Frederick County, Md.

MOTHER 14. Maiden name Lucinda Kelly

MOTHER 15. Birthplace Adams County, PA

16. Informant Norman Utz

Address Littlestown (PA R.D.1)

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 22. 1946 (month) (day) (year)

Cemetery or crematory Monrovia Cemetery

Location New Market, Maryland

16. Funeral director J. W. Little & Son

Address Littlestown PA. Per R.A. Little

19. Dec-19 1946 (Date rec'd by registrar) Ethel M. Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1946, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 14 1946, to Dec. 19 1946, and that I last saw him alive on Dec. 14 1946

Immediate cause of death	DURATION
Coronary Occlusion	1/2 hour
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. R. Potter M.D.
M. D. or other

Address Littlestown, Pa Date signed 12-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11985

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, Institution, or street address where death occurred:
25-7 E. Main
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 25-7 E. Main
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Myra Wagner

3. (b) Social Security Number 213-05-1565

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife Columbus M. Wagner
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 1885

8. AGE: Years 61 | Months 6 | Days 23 | If less than one day ... hrs. ... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Employee

11. Industry or business Shoe factory

FATHER 12. Name P. J. Hammond
13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden name Ruth Ann Smith
15. Birthplace Carroll Co. Md.

16. Informant Mrs Charles Brown
Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 29-1946 (month) (day) (year)
Cemetery or crematory Westminster Cemetery
Location Westminster, Md.

18. Funeral director H Bankard Son
Address Westminster Md.

19. 12/28 1946 H Kuhn (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1946, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to Dec. 27. 1946
and that I last saw h... alive on Dec 27. 1946

Immediate cause of death	DURATION
Renal Carcinoma Dilatation	10 Months
Due to Chronic Myocarditis	Several years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury Injured at work?

23. SIGNATURE Chas R Fout MD
M. D. or other
Address Westminster Md. Date signed 12-27-46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

11986

Reg. Dist. No. 75 0

1. PLACE OF DEATH:
County: Carroll
City or town: Ebbvale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Ebbvale
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edward J. Weaver

3.(b) Social Security Number:

4. Sex: M
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Amanda Weaver
6.(c) If alive, give age: Deceased years
7. Birth date of deceased (mo., day, yr.): Aug. 13 1862

8. AGE: Years: 84 Months: 4 Days: 1 If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Weaver
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Ross Weaver
Address: Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-15-46 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester Md

18. Funeral director: Jacob Weaver Sons
Address: Manchester Md

19. Dec. 15 1946 Mrs. W. P. S. Demmer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14 1946 at 12:05 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ____ 19__ to ____ 19__
and that I last saw h__ alive on ____ 19__

Immediate cause of death	DURATION
Burned to death	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 12/14/46
Where did injury occur? Ebbvale (City or town) Carroll (County) (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: House burned Injured at work? No

23. SIGNATURE: James T. Monk Deputy Medical Examiner M. D. or other
Address: Westminster Md Date signed: 12/14/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

11987

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Ebbvalley Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Ebbvalley Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lillie Grace Weaver

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of ~~husband~~ or wife: Samuel Weaver
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): July 7 1889

8. AGE: Years	Months	Days	If less than one day
57	5	7	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Keeper Wife
11. Industry or business:
FATHER 12. Name: William H Walthelm
13. Birthplace: Maryland
MOTHER 14. Maiden name: Martha F. Coats
15. Birthplace: Maryland
16. Informant: Samuel Weaver
Address: Manchester Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-18-46 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester Md
18. Funeral director: Paul Wilhide Sons
Address: Manchester Md
19. Dec. 15 1946 (Date rec'd by registrar) Mrs. W. R. S. Benner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14 1946, at 12:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on ..... 19.....

	DURATION
Immediate cause of death: Burned to death	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 12-13-46
Where did injury occur? Ebbvalley Carroll Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: House burned Injured at work?

23. SIGNATURE: James T. Thomas Deputy Medical Examiner M. D. or other
Address: Westminster Md Date signed: 12/14/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93rd)

CERTIFICATE OF DEATH

11988

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs 5 mo 23 da

Hospital, institution, or street address where death occurred: Spring field State Hospital

How long in hospital or institution? 7 yrs 5 mo 23 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Monty Co.

City or town: Gaithersburg Md. (If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Lillie Agnes Whalen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
1	W	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 14 - 1886

8. AGE: Years: 60 | Months: 2 | Days: 13 | If less than one day: hrs. min.

9. Birthplace: Gaithersburg Md. (Town, county, and state)

10. Usual occupation: dependent

11. Industry or business:

FATHER — 12. Name: Michael Whalen

FATHER — 13. Birthplace: Md

MOTHER — 14. Maiden name: Alice Day

MOTHER — 15. Birthplace: Md

16. Informant: Edith E Whalen

Address: 4517 - 37th St. Brentwood

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-29-44 (month) (day) (year)

Cemetery or crematory: Forest Oak

Location: Gaithersburg Maryland

18. Funeral director: Rom. R. Barber

Address: Laytonsville maryland

19. Dec 29 1946 (Date rec'd by registrar) C. Henry Wiles Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 26 1946, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3d 1937 to Dec 26 1946

and that I last saw him alive on Dec 26 1946

Immediate cause of death	DURATION
Chronic Myocarditis	?
Due to:	
Epilepsy	50 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. J. Gastin M.D. (M. D. or Other)

Address: Sykesville Md. Date signed: 12/26/46

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

11989

Reg. Diat. No. 782

1. PLACE OF DEATH:

County: Carroll

City or town: Ebvale Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Ebvale Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Hanna J. Wilhelm

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widow

6.(b) Name of husband or wife: William H Wilhelm Deceased 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan. 19 1864

8. AGE:

Years	Months	Days	If less than one day
82	10	25	____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Home Duse Wife

11. Industry or business

FATHER — 12. Name: John Coats

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Jemita Buckingham

MOTHER — 15. Birthplace: Maryland

16. Informant: Samuel Weaver Address: Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-15-46 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Manchester Md

18. Funeral director: Jack Winkelmeyer Sons

Address: Manchester Md

19. Dec. 15 1946 (Date rec'd by registrar) Mrs. W. R. S. Demuth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14 1946, at 12:05A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____

and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Burned to death	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 12-14-46

Where did injury occur? Ebvale (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: House burned Injured at work? No

23. SIGNATURE: James F. Thorat, Deputy Medical Examiner M. D. or other

Address: Westminster Md Date signed 12-14-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11990

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months, 3 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Harwood (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ALICE LOUISE WILSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 19, 1920

8. AGE: Years	Months	Days	If less than one day
26	6	18	..... hrs. ..... min.

9. Birthplace West River, Md. (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER
12. Name Daniel Owens
13. Birthplace Maryland

MOTHER
14. Maiden name Marie Hall
15. Birthplace Lothan, Md.

16. Informant Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 9-1946 (month) (day) (year)
Cemetery or crematory Moses Mem
Location Drury, A.A. Co. Md.

18. Funeral director D. A. Haught & Son
Address Galesville Md

19. Dec. 7, 19 46 (Date rec'd by registrar) Albert R. Somerville Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7, 1946 at 2:40A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 4, 1946 to Dec. 7, 1946 and that I last saw her alive on December 7, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosi	Dec. 1940
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Reuben D. Ruman M.D. M. D. or other
Address Henryton, Md. Date signed 12-7-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

1-25

2-740 - 1-10

1199

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 month, 8 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Dundalk (If outside city or town limits, write RURAL and give nearest town)
Street No. 140 Avon Beach Road (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MILTON WINSTON

3.(b) Social Security Number: 216-09-7894

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Hilda Winston
6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): May 17, 1912

8. AGE: Years	Months	Days	If less than one day
34	6	22	hrs. min.

9. Birthplace: Sparrows Point, Md. (Town, county, and state)
10. Usual occupation: Mechanic
11. Industry or business

FATHER
12. Name: Walter Winston
13. Birthplace: Rocky Mount, N. C.

MOTHER
14. Maiden name: Bessie Staten
15. Birthplace: Talbert, N. C.

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-12-46 (month) (day) (year)
Cemetery or crematory Mt. Calvery.
Location Anne Arundel Co, Md.
18. Funeral director Mrs. Robert Elliott
Address 1129 N. Caroline St. Balto.
19. 12/9 (Date rec'd by registrar) 19 46 Albert R. Smallwood Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9, 1946, at 8.55A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31 1946 to Dec. 9, 1946 and that I last saw him alive on December 9, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben W. Freeman, M. D. M. D. or other
Address Henryton, Md. Date signed 12/9/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A-5 9-45-15M

1-25

2-740-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

11992 780

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Taneytown Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Pleasant Valley
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Miss Laura Jane Zepp

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	singke

6.(b) Name of husband or wife none

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 10, 1863

8. AGE: Years	Months	Days	If less than one day
83	5	18	..... hrs. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Emanuel Zepp

13. Birthplace Md

MOTHER 14. Maiden name Savilla Hahn

15. Birthplace Md

16. Informant Hubert J. Null

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec, 30, 1946 (month) (day) (year)

Cemetery or crematory St. Matthews

Location Pleasant Valley, Md.

18. Funeral director C. O. FUSS & SON

Address Taneytown, Md.

19. Dec. 30, 1946 (Date rec'd by registrar) Ethel M. Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1946, at 2:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11 1945, to Dec. 28 1946 and that I last saw h.e.r alive on Dec. 28 1946

	DURATION
Immediate cause of death Bronchopneumonia	2 days
Type Undetermined	
Due to Acute Bronchitis	4 days
Due to	
Other conditions Chronic Myocarditis + Myocardial Degeneration, Non Rheumatic, Benign Arteriosclerosis 15yrs.	

(Include pregnancy within 3 months of death)

Major findings of operation None Done Date of op.

Autopsy results None Done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. S. McVaugh M. D.
M. D. or other

Address Taneytown, Md. Date signed 12/29/46

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